

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038930

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 739

FILED OCT 31 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>COLUMBIA</u>		c. CITY OR TOWN <u>HARRISONVILLE</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>UNIVERSITY OF Mo. Med. Center</u>		d. STREET ADDRESS (If outside, give location) <u>GEN DELIVERY</u>	
3. NAME OF DECEASED (Type or print) <u>OLLIE</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-90</u>
9. AGE (last birthday) <u>73</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>LOUP</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (City and state or country) <u>LOUP</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>WILBUR W. ROSS</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA WINTERS</u>	
14. NAME OF HUSBAND OR WIFE <u>UNIVERSITY OF Mo. Med Records</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>COLUMBIA Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE</u> DUE TO (b) <u>SEPTIC SHOCK</u> DUE TO (c) <u>URINARY INFECTION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u>11:45</u> a.m. <u>11:45</u> p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>OCT 18, 1963</u> to <u>OCT 25, 1963</u> and last saw her/him alive on <u>OCT 25, 1963</u> Death occurred at <u>11:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert Ross, Jr. M.D.</u>		22b. ADDRESS <u>U. Mo. Med. CTR.</u>	
22c. DATE SIGNED <u>OCT 26, 1963</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>10/26/1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lees Summit Cem</u>	
23d. LOCATION (City, town, or county) <u>Lees Summit Mo</u>		24. FUNERAL DIRECTOR <u>LANGFORD F.H.</u>	
25. DATE RECD. BY LOCAL REG. <u>OCT 26 1963</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald L Roberts

Licensed Embalmer No. 4722

P. O. Address Columbia MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.